

ANESTHESIA—A MEDICAL SPECIALTY*

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OCTOBER 16, 1846, when Dr. W. T. G. Morton gave the first public demonstration of ether anesthesia at the Massachusetts General Hospital, was a history making day for anesthesia. This event also made possible the unprecedented advance of surgery of the past fifty years, for without anesthesia, surgery would still be only a last resort measure and any marked advance could not have been made.

Even as early as 1846, without the means of rapid communication we have today, the news of this event rapidly spread around the world and there was a clamor for ether everywhere, and, there being no trained anesthetists or teachers, the surgeons early established a dangerous precedent by allowing anyone to handle the agent. I wish to take a few minutes of your time to review the rise of the anesthetist—not anesthesia.

If the detail men of those old days were anything like those of today, I can imagine one entering Doctor Jones' office, telling him of the simplicity of the application of the drug—how anyone could use it with safety (as they now do to us with the newer anesthetic preparations)—just drop it on a towel or handkerchief and the patient would go to sleep and the surgeon could do his work at leisure with no thought of anything but setting a fracture, doing the delivery, operating, or what not.

Under such conditions it is not surprising that the administration of the anesthetic was relegated to the nurse, or relative, or someone off the street, as the case might be. Soon charlatans were procuring supplies of ether and traveling over the countryside picking up jobs as they could. This naturally was followed by a high mortality and had it not been that anesthesia was absolutely essential to surgical advance, I doubt if anesthesia could have withstood the disrepute which this early practice placed upon the use of ether. But even from the date of its discovery the surgeon realized that it had become an essential factor in his work.

Because of the high mortality and morbidity, physicians of the time began to take more care and precautions. They realized the dangers of anesthesia and took a definite interest in overcoming these dangers, studying and training themselves in the administration of anesthetic agents. The work of these men is responsible for the specialty of anesthesia of today.

Advance in the specialty of anesthesia was at first slow. The formation of such organizations as the Associated Anesthetists of the United States and Canada, with its regional branches; The International Anesthetic Research Society, and local associations for the advancement of anesthesia by physicians gave great results.

Research by the medical profession has produced new anesthetic agents, new methods and newer and safer apparatus. All these advances have so broadened the scope of anesthesia that it is an alluring field of endeavor for any physician.

The specialty has been somewhat retarded by the attitude assumed by most of our medical schools, and by that of the American Medical Association. Sufficient stress has not been given this important subject. Why should not all medical schools impress the medical student with the importance of anesthesia so that a greater number of physicians will take up the subject in a serious way as a life work, thus making future advance possible. The second retarding factor is the unwillingness of the American Medical Association to grant anesthesia a section. This is the only national English speaking medical organization that has not recognized anesthesia by granting it a section and I hope to see the day when the American Medical Association will grant the recognition this specialty in medicine so justly deserves.

Lay persons administering anesthetics, regardless of experience, are still technicians and can never be more, for their fundamental training does not fit them for more. Under these conditions the surgeon has no one with whom he can divide responsibility. He must interrupt his own work to keep himself acquainted with the patient's condition and be ready to order any stimulants or medication indicated. This is manifestly unfair to both patient and surgeon. Under lay anesthesia when an emergency arises during surgery, when the patient is in poor condition—just at a time when the surgeon should have his mind and hands free to put his full attention and energy into his work—he must stop, acquaint himself with the patient's condition (which he is not in a position to determine without examination) and order the indicated remedy, with resultant loss of time.

Anesthesia is definitely the practice of medicine. Some deny this and state that the technician has an equal right to administer an anesthetic as to give a hypodermic. With this I disagree. An emergency arises, stimulation is *ordered* (prescribed) by the anesthetist and given. In that act anyone but a licensed physician has violated the California Medical Practice Act, for only a licensed physician can lawfully prescribe under this Act. If the anesthetist is not able to so prescribe by being a licensed physician, the surgeon must be disturbed from his trying work to do a duty from which he should be relieved. How many of you have not at times carried a patient through an emergency without in any way disturbing the surgeon's work or distracting his attention. If the surgeon loses valuable minutes at a critical time the patient may suffer irreparable injury.

The anesthetist should be in a position to know the patient's condition before surgery. He should examine the patient and determine for himself the condition of heart and lungs, should familiarize himself with and be able to interpret the laboratory and x-ray findings in relation to the anesthetic risk the patient presents. He should be able

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to advise and prescribe preoperative medication. In other words he should be a medical consultant as well as an anesthetist. Who but a licensed physician can perform these services?

In case of death under anesthesia the courts have held the hospital liable where technician anesthetists have been used, holding that all reasonable precautions were not taken in the case. This is a risk that a hospital takes each time an anesthetic is administered by a lay anesthetist.

In closing I wish to make a plea for:

First: More adequate instruction in anesthesia in our medical schools, that the science and specialty of anesthesia may be advanced and the lives of patients safeguarded.

Second: Justified recognition by the American Medical Association in the formation of a Section in Anesthesiology. I ask you all to work to these ends.

I also wish to reiterate and stress the following:

First: That anesthesia is the practice of medicine and is a medical specialty.

Second: That the patient is safeguarded and the surgeon is freed to do better work by concentrating his whole attention on his own field, when a competent physician administers the anesthetic.

Third: That the one and only excuse for a lay technician in the field of anesthesia is the impossibility of obtaining a medical anesthetist.

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POSTURAL TENSIONS FOR NORMAL AND ABNORMAL HUMAN BEHAVIOR— THEIR SIGNIFICANCE*

PART II

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WE have briefly discussed postural tensions in relation to movement, and we wish now to sketch postural tensions in relation to sensation.*

POSTURAL TENSION IN RELATION TO SENSATION

Diagram 3 shows how the exteroceptor and its environmental stimuli are associated with the proprioceptor and internal stimuli. Our mentation is composed of streams of exteroceptive sensations blended with proprioceptive sensations into a common order, making the content of consciousness or the stream of mentation.

Now, practically all of our exteroceptors, except the visual, are wide open to their particular environmental stimuli, and if we did not have some means of shutting off their percussions from reaching our vital functions we would soon be in a state of maniacal panic reacting without self-control.

We seem to perform this continuous self-protective function through the postural tensions

of the cerebrospinal and autonomic muscle systems, constituting attitude. Through postural attitudes we are able to focus attention, or rather regulate our reactivity, so that we locally or generally raise or lower the threshold of reactivity reflexly as we need, to maintain our equilibrium and sense of proportions of the destructive and constructive environmental forces as they are related to our potential strength and weakness and the nature of our affective needs.

Naturally, when we lose control of our affective pressure, and it changes despite our best efforts, the poise of our attitude breaks down and we can see our postural tensions (bodily and facial expressions) change. Through these changes we read the nature or state of one another's affective pressure or emotions and the degree of his control of them.

INTERPRETATION OF POSTURAL TENSIONS

This brings us to a new language of symptoms and meanings of postural tensions in relation to attitude and character formation. As a people we are still quite ignorant in our understanding of the meanings of our own postural tensions. We are more adept at seeing through others than seeing through ourselves (whom we would have perfect), until we reveal ourselves to others who then kindly or cruelly show us what they see in us, much to our benefit or chagrin.

As physicians, our clinical responsibilities compel us to burden ourselves not only with the study of the symptoms of organic diseases, but with the study of the more elusive and subtle meanings of symptoms of functional diseases, of the psychoses, and particularly those distressing neuroses of hypertension and hypotensions of the vital organs which have impaired but not overcome the integrity of the personality.

The most serious of the postural tensions are not those which are adapted to control the influence upon us of environmental situations, but those which are used to suppress emotions and wishes and memories within ourselves of which we are fearful because they are ridiculous, wrong, dangerous, or asocial. As the suppressed affective pressure accumulates and becomes intense, the viscera assume hypertension like compressed springs as if the affective pressure accumulated in the tensions of the neuromuscular circuits. Our clinical experience shows that such distressing states of functional hypertension may involve any of the vital organs containing muscle tissue. We find it in the heart and arterial and capillary blood vessels, the pharynx, bronchial tubes, esophagus, stomach, small intestine, colon, rectum, and genito-urinary organs. Sometimes emergency surgical interference is necessary, but far more often it is decidedly unnecessary and, for the future of the patient, most unwise. Many of our surgeons need to be educated about the psychopathology of spastic and flaccid tonus of the viscera.

The continuous problem of everyday life for every man is to solve his personal relations so as to fit them to his affective pressure, and solve

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